STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29E021	A. BUILDING _____ B. WING _____	11/05/2010

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GAYE HAVEN INTERMEDIATE CARE FACILITY	1813 BETTY LANE LAS VEGAS, NV 89115

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on 11/4/10 through 11/5/10, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was 17 residents. The sample size was eight residents, which included one closed record. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified:	F 000		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280		12/20/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	Continued From page 1 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents (or their legal representatives) were afforded the opportunity to participate in meetings planning their care. Findings include: A group interview was conducted with eight alert and oriented residents on 11/4/10 at 2:30 PM. When asked if they were invited to meetings in which staff planned their nursing care, medical treatment, and activities, the residents responded that they had not. Upon review of residents' clinical records, there was no evidence that care planning conferences, which included interdisciplinary team members and the resident, family member, or legal guardian, were being formally conducted. The Social Worker indicated in an interview on 11/5/10 at 7:45 AM that residents, or their family members or legal guardians, were not invited to conferences to discuss their comprehensive plan of care. According to the Social Worker and the Director of Nursing, the facility did not have a policy outlining who would be expected to attend care planning conferences, how often the conferences would occur, how the facility would, to the extent practicable, encourage each	F 280		

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F 280	Continued From page 2 resident to participate, and how this information would be documented in the clinical record.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a physician's order was clarified and carried out for 1 of 8 residents (Resident #2). Findings include: Resident #2 was admitted to the facility on 4/11/07, and readmitted on 6/24/09, with diagnoses including diabetes, chronic obstructive pulmonary disease, psychosis, and hypothyroidism. Physician orders for diabetes included Glyburide 10 mg (milligrams) every morning, Metformin 1000 mg twice daily with meals, Januvia 100 mg every morning, and "test blood sugar as needed for NIDDM (non-insulin dependent diabetes mellitus)." Review of Resident #2's record and medication administration record (MAR) revealed no indication that the resident's blood sugar was being tested. An order on 8/5/10 read, "1 Accucheck meter for blood sugar testing; 1 lancet; and 1 test strips."	F 309		12/20/10

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F 309	Continued From page 3 The medication pass nurse, Employee #3, was interviewed on 11/5/10 at 10:00 AM. The nurse explained that on 8/5/10 she noticed that Resident #2's glucometer (Accucheck meter) was not working, and therefore an order for a new one was written. As of 11/4/10, a new glucometer was not available for use by Resident #2. Employee #3 communicated that she faxed the order to the Pharmacy twice - once in August and once in September - and did not hear back from them. The nurse acknowledged she did not follow up with the pharmacy regarding the glucometer. When asked about the order for testing blood sugar, the employee stated, "We can't do accuchecks here. I guide him (the resident). (When it was working) the glucometer was used once every two weeks, because I didn't understand the order." On 11/5/10 at 11:45 AM, the Director of Nursing agreed that the facility should have ensured Resident #2 had a new Accucheck meter as ordered and that the order should have been clarified.	F 309		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		12/20/10

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F 371	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to ensure the kitchen was maintained in a sanitary manner. Findings include: A tour of the kitchen on 11/4/10 revealed: The low-temperature dish machine was not dispensing any chlorine sanitizer. The State food inspector also confirmed no sanitizer was being dispensed by testing the dish machine with chlorine test strips. The kitchen manager reported a technician recently repaired the dish machine and that she assumed the sanitizer was dispensing properly because there were chlorine vapors. The designated handwashing sink was full of dirty dishes, making it difficult for staff to wash their hands. An opened container of sour cream had a manufacturer's stamped use-by date of 10/26/10. The floors behind the main refrigerator were observed with accumulated dirt and food debris.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 425		12/20/10

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F 425	Continued From page 5 law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, document review and interview, the facility failed to have a system in place to ensure the physician received recommendations from the consultant pharmacist regarding psychopharmacological medications for 2 of 8 residents (Residents #1 and #2). Findings include: Resident #1 Resident #1 was admitted to the facility on 12/22/06, with diagnoses including dementia, depression, and oropharyngeal carcinoma. Current medication orders included the antipsychotic Seroquel 400 mg (milligrams) at bedtime for psychosis. Review of the resident's clinical record revealed a DISCUS (dyskinesia identification system	F 425		

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F 425	Continued From page 6 condensed user scale) assessment form, completed by the Director of Nursing (DON) on 1/13/10, with regard to the antipsychotic medication Seroquel. The assessment indicated the resident had symptoms of lip smacking and thrusting of the lower lip (in comparison, the previous assessment conducted six months earlier on 7/19/09 indicated no symptoms). The DON wrote "10" in the Total Score box and circled "probable TD (tardive dyskinesia)" in the conclusion section of the form. Record review also revealed that the dosage of Seroquel increased from 100 mg to 300 mg each day on 5/22/09. On 8/31/09, this dosage was further increased to 500 mg each day. Notes written by the social worker on 9/14/09 read, "She (Resident #1) also now has an uncontrolled mouth movement that did not appear as prevalent in the past..." On 11/6/09, the dosage of Seroquel was changed to 400 mg daily and remained unchanged at the time of review on 11/4/10. The Medication Regimen Review form, completed monthly by the facility's consultant pharmacist, indicated a recommendation on 7/23/10 to decrease Seroquel because of the total score of 10 on the DISCUS form. There was no documented evidence in the resident's record that the physician was aware of this recommendation by the pharmacist. The consultant pharmacist was interviewed on 11/4/10 at 2:00 PM. The pharmacist confirmed that she wrote the recommendation to reduce Seroquel because she felt the score of 10 on the most recent DISCUS form was considered high. The pharmacist stated the DISCUS assessment	F 425		

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F 425	Continued From page 7	F 425		

was being used by the facility "as a good marker for psychotropic meds to see if dosages should be changed." The pharmacist explained that she prepared a report of her recommendations and gave the report to the DON when she came back the following month.

The DON was interviewed on 11/4/10 at 1:00 PM. The DON explained that whenever she received recommendations from the pharmacist, she would verbally communicate this information to the physician. The DON acknowledged she could not provide evidence the physician received all the recommendations, or what the physician's response was to the pharmacist's recommendations, as there was no system in place to document this information. The DON further reported there was no facility policy related to the process of communication between the pharmacist and the physician.

Resident #2

Resident #2 was admitted to the facility on 4/11/07, with readmission on 6/24/09. Diagnoses included diabetes, chronic obstructive pulmonary disease, dementia, and hypothyroidism. Current medication orders included the antipsychotic Risperdal 0.5 mg three times daily, which was initiated at this dosage on 8/26/09.

According to the Medication Regimen Review form, the pharmacist made a recommendation on 12/14/09 to reduce Risperdal. There was no documented evidence in Resident #2's record that the physician was aware of this recommendation. The DON could not provide information regarding the physician's response to decreasing the dosage of Risperdal.

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F 425	Continued From page 8 The pharmacist made another recommendation on 8/18/10 to reduce Risperdal. Again, there was no documented evidence the physician was aware of this recommendation. According to the "Consultant Pharmacist Services Provider Requirements" procedures, provided by the contracted pharmacy corporation, "The consultant pharmacist, or designee, provides pharmaceutical care services, including but not limited to.....communicate to the responsible prescriber and the Director of Nursing potential or actual problems detected and other findings related to medication therapy orders at least monthly. Communicate recommendations for changes in medication therapy and monitoring of mediation therapy...Provide inservice educational programs to nursing staff on a medication-related topic at least annually...Assist the nursing care center staff on development, implementation, evaluation, and revision of pharmaceutical service procedures that address resident needs...Participate and provide a report to the nursing care center's Quality Assessment and Assurance Committee's quarterly meeting...."	F 425		
F 463 SS=F	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure there was a functioning call bell	F 463		12/20/10

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F 463	Continued From page 9 system throughout the facility. Findings include: On 11/4/10 at 1:30 pm, Resident #5, who resided in Room #10 was interviewed. The resident indicated his call bell was not functioning. On 11/4/10 at 2:45 PM, Resident #4 in Room 8 was asked to check his call bell. When Resident #4 pressed the call bell light at the bedside, there was no audible signal and the light in the hallway did not illuminate. Resident #4 then pulled the call bell in the bathroom of Room #8, and the hall light illuminated and an alarm was audible. At 3:10 PM, two CNA (Certified Nursing Assistant) staff were asked to check the call bell system in all the resident rooms, bathrooms, and the shower. The call bell test revealed: 1) The call bell system worked in the bathrooms of Rooms #4, #5,# 6, #8 and #10; the common shower room; at the bedside in Room #5. 2) The call bell system did not work in the bathroom of Room #9; at the bedside in Rooms # 4, # 6, #8, #9, and #10. The CNA staff explained that when the call bell system was functioning, the call bells were visible in the hallway by the light above the door. There was also an alarm that was audible when a resident rang the call bell in the bathroom. The CNA added there was also a light illuminated above the door in the Dining Room, as well as an audible alarm, when a resident's call bell was ringing. At 3:15 PM the Director of Nursing was informed of the non-functioning call bell system. She indicated she was not aware the system was not	F 463		

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F 463	Continued From page 10 functioning properly. At 3:30 PM the evening charge nurse was informed of the problems with the call bell system. She indicated the call bells normally light up at the nurse's station indicating which room the resident was calling from. Observation of the nursing station throughout the day on 11/4/10 revealed the nursing station was usually locked and no staff were sitting at the station to identify if call bells were ringing. At 3:30 PM the call bell system panel was observed at the nurse's station. This did not appear to be functioning since the buttons did not light up to indicate the room where the call bell was ringing. At 3:30 PM, the charge nurse tested the call bells in several rooms, including Rooms # 4 and #6. The call bells were not functioning in either of these room, at the bedside or in the bathroom. The charge nurse verbalized, "I think we blew a fuse." The charge nurse indicated she would try to locate the fuse and fix the problem. At 4:30 PM, the maintenance staff returned to the facility and tested the call bells in all the rooms, bathrooms and the common shower. None of the call bells were functioning.	F 463		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		12/20/10

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F 520	Continued From page 11 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure its quality assessment and assurance committee included a designated physician. Findings include: On 11/5/10 at 9:15 AM the Social Worker was interviewed regarding the facility's quality assessment and assurance (QAA) committee meetings. The Social Worker showed some copies of attendance sign-in sheets. Included on the sheets was a list of various disciplines with corresponding signatures. There were no signatures next to the disciplines of Physician and Pharmacist. The Social Worker communicated that neither the	F 520		

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F 520	Continued From page 12 physician nor the consultant pharmacist attended the QAA meetings, to assist in developing and implementing appropriate plans of action to correct identified quality deficiencies. The Director of Nursing (DON) confirmed that a physician did not attend the QAA meetings and indicated that the facility's medical director would be the designated physician. The facility did not have a QAA policy outlining such aspects as the times and composition of the meetings, and how issues and quality deficiencies would be identified, resolved, monitored, and evaluated.	F 520		